VERIFICATION OF GROUP LIFE INSURANCE BENEFITS

Section One:
(To be completed by the Provider of Viatical Settlements or Producer of Viatical Settlements)

Insurance Company	**Name of Employee/Member**
Employer/Policyholder Name	**Insured's Date of Birth**
Policy Number	**Insured's Social Security Number**
Certificate Number	**Employee/Membership Number**

Please provide the information requested in Section Two or Section Three, as appropriate, with regard to the individual and coverage described, in accordance with the attached authorization. In addition, please provide the forms checked below which are available from your company to complete a viatical settlement transaction:

- ☐ Absolute Assignment
- ☐ Change of Beneficiary (irrevocable if applicable)
- ☐ Disability Waiver of premium claim or
- ☐ Disability Waiver of premium award letter

_____ _____

Signature of representative of Provider of Viatical Settlements or Producer of Viatical Settlements — Date

_____

Full name and address of Provider of Viatical Settlements or Producer of Viatical Settlements

Section Two:
(To be completed by the employer/group policyholder and the insurer. Both should indicate the parts they completed.)

1. BASIC COVERAGE:

a) Is the plan self-insured or is coverage provided under a group policy issued by a life insurance company? _____

If by a group policy, please provide the name of the insurance company for BASIC life insurance coverage:_____

b) Effective date of BASIC life insurance coverage:_____

c) Face amount of BASIC life insurance:_____

d) Does BASIC coverage plan have contestable provisions? ☐ no ☐ yes

e) Is Basic coverage subject to a suicide provision? ☐ no ☐ yes

f) Monthly premium paid by employer/group policyholder for BASIC life insurance: $____

g) Monthly premium paid by employee/insured for BASIC life insurance: $_____

h) Is BASIC life insurance coverage ☐ Term ☐ Universal Life?
If Universal Life, please indicate cash value, if any: _____ Is this amount payable in addition to the face amount? ☐ no ☐ yes

i) Is coverage in force? ☐ no ☐ yes

j) When is next premium due? _____

k) Has employee's coverage under this plan ever been reinstated? ☐ no ☐ yes
If yes, date of reinstatement: _____

2) SUPPLEMENTAL (OPTIONAL) COVERAGE

a) Insurance Company for SUPPLEMENTAL life insurance coverage:_____

b) Effective date of SUPPLEMENTAL life insurance coverage:_____

c) Face amount of SUPPLEMENTAL life insurance:_____

d) Does SUPPLEMENTAL coverage plan have contestable provisions? ☐ no ☐ yes

e) Is SUPPLEMENTAL coverage subject to a suicide provision? ☐ no ☐ yes

f) Monthly premium paid by employer/group policyholder for SUPPLEMENTAL life insurance: $_____

g) Monthly premium paid by employee/insured for SUPPLEMENTAL life insurance: $____

h) Is SUPPLEMENTAL life insurance coverage ☐ Term ☐ Universal Life?
If Universal Life, please indicate cash value, if any: _____ Is this amount payable in addition to the face amount? ☐ no ☐ yes

i) Is coverage in force? ☐ no ☐ yes

j) When is next premium due? _____

k) Has employee's coverage under this policy been reinstated within the last two years?
☐ no ☐ yes If yes, date of reinstatement: _____

3) DISABILITY WAIVER OF PREMIUM

a) Does plan provide for waiver of premium in the event of employee/insured's disability?
BASIC ☐ no ☐ yes What is the waiting period? _____
SUPPLEMENTAL ☐ no ☐ yes What is the waiting period? _____

b) Are premiums currently being waived under disability premium waiver?
BASIC? ☐ no ☐ yes
SUPPLEMENTAL? ☐ no ☐ yes

c) Who pays premiums under disability premium waiver?

BASIC ☐ Insurance carrier ☐ Employer

SUPPLEMENTAL ☐ Insurance carrier ☐ Employer

d) What was the date of approval?_____

e) Next review date?_____

f) If the insured is no longer eligible for waiver, what amount of coverage can be converted to an individual policy? $_____

i) Will a new suicide/contestability clause be in effect for the converted policy?

☐ no ☐ yes

ii) Will assignee be notified if insured is no longer eligible for waiver? ☐ no ☐ yes

4) BENEFICIARIES, ASSIGNMENTS AND LIMITATIONS

a) Who are the primary beneficiaries of the coverage(s)?

BASIC_____

SUPPLEMENTAL:_____

b) Is any beneficiary under this policy designated irrevocably, or is insured otherwise limited in designation of new beneficiaries? ☐ no ☐ yes

c) Can this coverage be assigned?

BASIC ☐ no ☐ yes

If yes, to a corporation? ☐ no ☐ yes To someone not related to insured? ☐ no ☐ yes

SUPPLEMENTAL ☐ no ☐ yes

If yes, to a corporation? ☐ no ☐ yes To someone not related to insured? ☐ no ☐ yes

d) Do records show any assignments of record? ☐ no ☐ yes

e) Do records show any outstanding liens or encumbrances of record? ☐ no ☐ yes

f) The following parties (as applicable) should indicate whether they will provide notice to the assignee if the master policy is terminated.

Group policyholder ☐ no ☐ yes

Third party administrator (if any) ☐ no ☐ yes

Insurance company ☐ no ☐ yes

g) Can Assignee convert the coverage without the permission of insured**?** ☐ no ☐ yes

5) ACCELERATED DEATH BENEFITS

a) Is there an Accelerated Death Benefit available under the coverage?

BASIC ☐ no ☐ yes

SUPPLEMENTAL ☐ no ☐ yes

b) Has request for Accelerated Death Benefit been made? ☐ no ☐ yes

c) Has payment been made under this provision? ☐ no ☐ yes

i) Amount paid: _____ Date paid: _____

ii) Is this amount a lien against death proceeds? ☐ no ☐ yes Interest rate____

iii) Can the remaining death benefit be assigned? ☐ no ☐ yes

6) MISCELLANEOUS

a) Is coverage portable?

BASIC ☐ no ☐ yes

SUPPLEMENTAL ☐ no ☐ yes

b) If insured is no longer eligible for coverage under the group, will Assignee be notified?

☐ no ☐ yes

c) If master policy discontinues, what amount can be converted to an individual policy? $_____

d) Is this plan administered by a third party? ☐ no ☐ yes

If yes, please provide the name, address and telephone number of administrator:

Name: _____ Title _____

Company name: _____ Department: _____

Street Address: _____

(No P.O. Box please)

City: _____ State: _____ Zip: _____

Telephone number: ( ) _____ Fax: ( ) _____

If a change of beneficiary form or assignment were to be made for this coverage, to whom should the completed forms be sent?

Name: _____ Title _____

Company name: _____ Department: _____

Street Address: _____

(No P.O. Box please)

City: _____ State: _____ Zip: _____

Telephone number: ( ) _____ Fax: ( ) _____

The answers provided reflect information in our files as of ____/____/____*(Month/Day/Year)*.

Signature: _____ Name: _____

Date: _____ Title: _____

Company: _____

Direct telephone number: ( ) _____ Direct fax number: ( ) _____

Information not provided by the employer may be obtained from the insurance company if different from administrator identified above:

Name: _____ Title _____

Company name: _____ Department: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone number: ( ) _____ Fax: ( ) _____

Section Three:

Under the terms of Utah Administrative Code Rule R590-222-10 covering requests for verification of coverage, the insurance company or the third party administrator named above is requested to complete the information not provided by the employer in Section Two, above, Items number:_____

7) Based on the information provided, do you intend to pursue an investigation for fraud in the underlying insurance contract? ☐ no ☐ yes

The answers provided to the identified questions reflect information in the files of the insurance company as of ____/____/____*(Month/Day/Year)*.

Signature: _____ Name: _____

Date: _____ Title: _____

Company: _____

Direct telephone number: ( ) _____ Direct fax number: ( ) _____